530-1
State law and regulations provide that when prior authorization is required, the Director shall require fully documented medical justification from providers that requested services are medically reasonable and necessary to prevent significant illness, to alleviate severe pain, to protect life or to prevent significant disability. (Welfare and Institutions Code §14133.3; §51303)

530-2
Retroactive approval of requests for prior authorization may be granted when a patient does not identify himself to the provider as a Medi-Cal beneficiary by deliberate concealment or because of a physical or mental incapacity to so identify himself. The request for retroactive authorization shall be accompanied by a statement from the provider certifying that the patient did not identify himself and the date the patient was so identified, provided such date is within one year after the month in which the service was rendered. The request for retroactive authorization shall be submitted within 60 days of the certified date of beneficiary identification. (§51003(b)(4))

530-3
"Prior authorization," "reauthorization" or "approval" means authorization granted by a designated Medi-Cal Consultant or by a Primary Care Case Management (PCCM) plan in advance of the rendering of a service after appropriate medical, dental or other review. (§51003(a))

530-4 REVISED 3/06
Authorization may be granted only for Medi-Cal benefits that are medically necessary and do not exceed health care services received by the public generally for similar medical conditions. The "Manual of Criteria for Medi-Cal Authorization" published by the Department in January 1982, and last revised on April 15, 2004, and herein incorporated by reference in its entirety, shall be the basis for the professional judgments of Medi-Cal Consultants or PCCM plans in their decision on authorizations for services or conditions listed in the Manual. Such authorization shall be valid for the number of days specified by the consultant up to a maximum of 180 days (120 days prior to June 5, 2000), unless otherwise specified. The consultant or PCCM plan may grant authorization for up to a maximum of two years when the treatment as authorized is clearly expected to continue unmodified for up to or beyond two years. (§51003(e))

530-5
Treatment authorization may be granted only for the lowest cost item or service covered by the program that meets the patient's medical needs. (§51003(f))

530-6
Experimental services are not covered under the Medi-Cal Program. (§51303(g))

530-7
Medi-Cal beneficiaries who are eligible for benefits under that program and for the same full or partial benefits under any other State or Federal medical care program or under other contractual or legal entitlements must use those other benefits before using Medi-Cal covered benefits. The requirement does not apply to beneficiaries under Medi-Cal capitated contracting arrangements unless the requirement is contained in the contract. (§51005(a))

530-8
When a proposed treatment meets objective criteria, and is not contraindicated, authorization for the treatment shall be provided within an average of five working days. When a treatment authorization request is not subject to objective medical criteria, a decision on medical necessity shall be made by a professional medical employee or contractor of the department within an average of five working days. (Welfare and Institutions Code (W&IC) §14133.9)

531-1
Full dentures, removable partial dentures that are necessary for the balance of a complete artificial denture, stayplates and reconstructions of removable dentures using standard procedures which exclude precision attachments or implants are covered benefits under the Medi-Cal Program subject to prior authorization. These services are covered only once in a five-year period by the Medi-Cal Program except when necessary to prevent a significant disability or to replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control. (§51307(e)(7))

531-1A
A removable partial denture is a benefit only when necessary for the balance of a complete denture. Balance is generally considered to be the presence of sufficient occluding posterior teeth affording satisfactory biomechanical support of a prosthetic appliance in all excursions of the mandible. Without such occlusion, a removable partial denture may be authorized to provide that support. (Denti-Cal Provider Manual 4-32, effective July 1998)

A removable partial denture shall be considered necessary for the balance of a complete artificial denture when, in the arch opposite the edentulous area, at least (excluding the third molars unless the third molar is occupying the position of the second molar and is in functional occlusion):

1. Four adjacent natural posterior teeth are missing on the same side.

2. Three adjacent natural posterior teeth are missing on the same side if the first bicuspid remains on the same side.

3. All four natural permanent molars are missing.

4. Five posterior permanent teeth are missing.

(Denti-Cal Bulletin, Vol. 8, No. 9, July 1992)

531-1B
"The five-year limitation on prosthetic appliances applies only to appliances provided by this [the Denti-Cal] program and means that one appliance of each type per arch may be authorized when reasonable and necessary in a five-year period, i.e., one stayplate, one partial denture, one reconstruction and/or one full denture per arch in the five-year period. A new five-year period commences on insertion of a replacement prosthesis." (Denti-Cal Provider Manual 4-32, effective July 1998)

531-1C
Replacement prosthetic appliances may be authorized more often than once in a five year period when:

1. Catastrophic loss of prosthetic appliance occurs. Requests may be approved for the replacement of a prosthesis that was lost due to some unfortunate incident and the loss of the prosthetic appliance could not reasonably have been prevented (e.g., fire, auto accident, reported theft, etc., and when the loss has been properly documented. The request for prior authorization should include a statement by the beneficiary or the beneficiary's representative explaining the nature of the loss or destruction.

2. Surgical or traumatic loss of oral-facial anatomic structures occurs. When a replacement prosthesis is required to replace or restore substantial loss of oral-facial structures by extensive weight loss, surgical intervention, or trauma and adequate documentation supports the request, authorization for the prosthesis may be granted.

3. There has been a complete deterioration of the denture base or teeth.

4. There has been a complete loss of retentive ability, vertical dimension, or balanced occlusion of existing dentures which cannot be restored by reline or reconstruction.

(Denti-Cal Provider Manual 4-32, 33, effective July 1998)

531-1D ADDED 2/05
Although a stayplate may be authorized to replace an anterior permanent tooth (teeth), posterior teeth also, may be included where reasonable and necessary; however, a stayplate shall not be authorized to replace posterior teeth only. (Denti-Cal Provider Manual 4-34)

531-2
The Court of Appeal invalidated §§51307(d)(4) and (d)(5) - dealing with laboratory-processed crowns and root canals - as these regulations were inconsistent with Welfare and Institutions Code (W&IC) §14132(h). The court held that these dental services would be authorized as long as they were "medically necessary to prevent significant illness, to alleviate severe pain, to protect life, or to prevent significant disability" as long as there were no less costly alternatives available.

The court further held that DHS' contention that the legislative direction was to provide services "to the extent practicable" did not authorize DHS to eliminate services enumerated in W&IC §14132(h) on the basis of fiscal considerations. (*Jackson* v. *Stockdale* (1989) 215 Cal.App. 3d. 1503)

531-3
Laboratory processed crowns for permanent teeth are a covered benefit subject to prior authorization. (§51307(e)(6))

531-3A
The following sets forth Denti-Cal procedures in regard to restorative dentistry and crowns:

GENERAL POLICIES - RESTORATIVE DENTISTRY

"6. The program provides amalgam, silicate, plastic, composite restorations or stainless steel crowns for treatment of caries. If the tooth can be restored with such material, any laboratory-processed crown or jacket is not covered."

(Denti-Cal Provider Manual 4-28, as revised effective July 1998)

GENERAL POLICIES - CROWNS

"1. Laboratory-processed crowns are benefits for permanent teeth if medically necessary pursuant to criteria (a) and (b) below. Prior authorization is required.

"a. The overall condition of the mouth, patient attitude, oral health status, arch integrity, and prognosis of remaining teeth shall be considered. The tooth and the remaining teeth must be no more involved than Periodontal Care Types II and III, as defined in General Policies - Periodontics (Procedures 450-499), §6.b. Approval will be predicated upon a supportable five-year prognosis.

"b. Longevity is essential and a lesser service will not suffice because extensive coronal destruction as defined below is supported by a narrative documentation, or is radiographically demonstrated and treatment is beyond inter-coronal restoration.

"(1) Molars must show traumatic or pathological destruction to the crown of the tooth, which involves four (4) or more tooth surfaces including two (2) or more cusps.

"(2) Anterior teeth must show traumatic or pathological destruction to the crown of the tooth and involves four (4) or more tooth surfaces including loss of one incisal angle.

"(3) Bicuspids (premolars) must show traumatic or pathological destruction to the crown of the tooth and involves three (3) or more tooth surfaces including one (1) cusp.

"2. Laboratory-processed crowns are generally allowable only once in a five-year period."

(Denti-Cal Provider Manual 4-30, as revised effective July 1998)

531-3B
Posterior laboratory processed crowns (procedure numbers 650, 651, 652, 653, 660 and 663) are no longer a benefit for adults 21 years of age and older except when the posterior tooth is used as an abutment for a fixed partial denture that meets current

program criteria, or for a removable partial denture with cast clasps and rests.

For laboratory processed crowns that were previously authorized, the provider must have cemented the crown prior to July 1, 2003 in order to be considered for payment.

(Welfare and Institutions Code (W&IC) §14132.88; Denti-Cal Bulletin Volume 17, Number 19 and Volume 19, number 23)

531-4
Vital pulpotomy for vital pulps and therapeutic pulpotomy for nonvital primary teeth are covered benefits. (§51307(b)(7)) In the Manual of Criteria for Medical Authorization, the following procedures are described as stated below:

Procedure 502, vital pulpotomy: A benefit for vital permanent teeth only. A single procedure is payable for the total service regardless of the number of treatment stages. Any acceptable and recognized method is a benefit where the procedure is justified and where the coronal portion of the pulp is removed. Preoperative periapical diagnostic x-rays are required to substantiate the need for treatment.

Treatment of dental caries with silver amalgam, silicate cement, acrylic, composite, plastic restorations or stainless steel crowns, except for incipient or nonactive caries in adults, is a covered benefit. (§51307(b)(8))

531-5
Removable partial dental prostheses are not a covered benefit under the Medi-Cal Program except when necessary for balance of a complete artificial denture. (§51307(d)(4))

531-6
The following sets forth Denti-Cal procedures in regard to periodontics:

GENERAL POLICIES - PERIODONTICS

"1. Periodontal services benefits, with the exception of emergency treatment (451), shall be limited to beneficiaries 18 years of age and older. Periodontal surgical benefits shall be extended to any individual when drug-induced gingival hyperplasia is documented, regardless of age.

"2. Periodontal care shall be limited to those patients:

"a. Who exhibit generalized periodontal pocket depths in excess of the 4-5 mm range.

"b. Who have a minimum of 4 isolated pockets of 5 mm or more in depth, and

"c. Where the isolated pockets of more than 5 mm in depth have failed to respond to conservative treatment, including emergency treatment of periodontal abscesses."

(Denti-Cal Provider Manual 4-23, effective July 1998)

531-7
"The following services are not covered Denti-Cal benefits:

"(1) Orthodontic services, except in the treatment of handicapping malocclusion for persons under the age of 21 and in the treatment of cleft palate deformities under the case management of California Children Services Program.

"(2) Treatment of incipient or nonactive caries in adults.

"(3) Cosmetic procedures.

"(4) Removable partial dental prostheses, except when necessary for balance of a complete artificial denture.

"(5) Extraction of asymptomatic teeth, except for:

"(A) Serial extractions required to minimize malocclusion or malalignment.

"(B) Teeth that interfere with the construction of a covered dental prosthesis.

"(C) Perceptible radiologic pathology that fails to elicit symptoms.

"(D) Extractions that are required to complete medically necessary orthodontic dental services.

"(6) Experimental procedures.

"(7) Procedures, appliances or restorations that:

"(A) Increase vertical dimension.

"(B) Restore occlusion.

"(C) Replace tooth structure lost by attrition.

"(D) Are for implantology techniques.

"(8) Pulp caps.

"(9) Fixed bridges, except when necessary for:

"(A) Obtaining employment.

"(B) Medical conditions which preclude the use of removable dental prostheses."

(§51307(d))

531-8
Endodontic therapy; root canal treatment in permanent teeth; recalcification including temporary restoration; Apicoectomy; and Apexification/Apexogenesis; are covered services, subject to prior authorization. (§51307(e)(5))

531-9
The statute dealing with authorizable dental benefits was amended effective August 15, 1993. Pertinent parts of that revision are set forth below:

(1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. The director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions which preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) The department may approve services for persons with special medical disorders subject to utilization controls, including those set forth above.

(Welfare and Institutions Code §14132(h))

531-10
The Denti-Cal changes mandated by Welfare and Institutions Code §14132(h), effective August 15, 1993, and regulations and policies issued pursuant to this statute, were enjoined from implementation. (Clark v. Belshé, U.S. District Court, E.D. Cal., Civ. §87-1700 JFM, 12/17/93)

531-11

The Denti-Cal Provider Manual contains the complete Manual of Criteria for Medi-Cal authorization (Dental Services). Orthodontic services for Handicapping Malocclusion are covered as follows:

1. The provision of medically necessary orthodontic services for handicapping malocclusion is limited to Medi-Cal eligible individuals under 21 years of age by a dentist qualified as orthodontist under the California Code of Regulations, Title 22, §51223(c).

2. The following policies and requirements apply to orthodontic services for handicapping malocclusion:

    a. The initial orthodontic examination, which includes the Handicapping Labio-Lingual Deviation (HLD) Index (procedure code 551) and the subsequent Study Models (procedure code 558), are required procedures to establish the medical necessity for orthodontic services for handicapping malocclusion. The HLD Index is the preliminary measurement tool used to determine the degree of the handicapping malocclusion. Completion of the initial orthodontic examination which includes the HLD Index does not require prior authorization. All other orthodontic services require prior authorization.

    b. A minimum score of 26 points on the HLD Index, or the indication that any of the five conditions listed below are present, is required for prior authorization of study models. The study model findings must confirm at least the minimum score attained on the HLD Index, or that one of the five conditions listed below is present, or that orthodontic services are necessary under Title 22 §51340.1(a)(2)(B) in order to obtain prior authorization of medically necessary orthodontic services. (This does not preclude authorization of x-rays and/or photographs in addition to study models if medically indicated.)

        (1) Cleft palate deformities; or

        (2) Deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate; or

        (3) Crossbite of individual anterior teeth that is destroying soft tissue; or

        (4) Overjet greater than nine (9) mm with incompetent lips, or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties; or

        (5) Severe traumatic deviations, e.g., loss of a premaxilla segment, osteomyelitis, gross pathology.

    c. Only cases with permanent dentition will be considered.

    d. Only cases with satisfactory completion of all necessary restorative and

periodontal conditions will be considered.

(Denti-Cal Provider Manual 4-44, as revised June 1999)

531-11A
Requests for prior authorization for EPSDT supplemental services shall include the following information:

(1) The principal diagnosis and significant associated diagnoses.

(2) Prognosis.

(3) Date of onset of the illness or condition, and etiology, if known.

(4) Clinical significance or functional impairment caused by the illness or condition.

(5) Specific types of services to be rendered by each discipline associated with the total treatment plan.

(6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.

(7) The extent to which health care services have been previously provided to address the illness or condition and results demonstrated by prior care.

(8) Any other documentation available which may assist in making the required determinations.

(§51340(d))

531-11B
Orthodontic services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries are covered only when medically necessary pursuant to the criteria set forth in the Medi-cal "Manual of Criteria for Medi-Cal Authorization", Chapter 8.1, as incorporated by reference in §51003(e), or when medically necessary for the relief of pain and infections, restoration of teeth, maintenance of dental health, or the treatment of other conditions or defects, pursuant to criteria in §51340(e)(1) or (e)(3). (§51340.1(a)(2))

531-11C
Denti-Cal has implemented guidelines to standardize the use of the HLD Index in the orthodontic program.

1. Study models must be of diagnostic quality. To meet diagnostic requirements, study models must be properly poured and adequately trimmed, with no large voids or positive bubbles present. Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion. Study models which do not meet the diagnostic requirements described above will not be accepted.

2. Only teeth which have erupted and are visible on the study models should be considered, measured, counted, and recorded.

3. If deciduous teeth are present and the patient is at least 13 years of age, the HLD Index evaluation may be performed.

4. In cases submitted for deep impinging bite with tissue destruction, the lower teeth must be clearly touching the palate, and tissue indentation(s) or other evidence of soft tissue destruction must be visible on the study models.

5. Either of the upper central incisors must be used to measure overjet, overbite (including reverse overbite), mandibular protrusion, and open bite. Do not use the lateral incisors or cuspids for these measurements.

6. The following definitions and instructions will apply when using the HLD Index to identify ectopic eruption:

   a. Examples of ectopic eruption (and ectopic development) of teeth include: 1) when a portion of the distal root of the primary second molar is resorbed during the eruption of the first molar; (2) transposed teeth; (3) teeth in the maxillary sinus; (4) teeth in the ascending ramus of the mandible; and (5) other situations where teeth have developed in locations rather than the dental arches.

   b. In all other situations, teeth deemed to be ectopic must be more than 50 percent blocked out and clearly out of the dental arch.

   c. In cases of mutually blocked-out teeth, only one will be counted.

(Denti-Cal Bulletin, Vol. 13, No. 8, May 1997)

531-11D
The general policies and requirements for orthodontic services for handicapping malocclusion apply to cases of cleft palate deformities when the patient's care is under the case management and authorization of the California Children Services program or when documented and medically necessary under the orthodontic dental services program. (Denti-Cal Provider Manual 4-44)

531-11E
Orthodontic benefits under the Denti-Cal program are limited to those specific to handicapping malocclusion. The Denti-Cal scope of benefits does not cover all orthodontic-related services.

> Orthodontic treatment is for permanent dentition except in cleft palate cases that are authorized and managed by CCS. Note: Primary teeth with no permanent successors are considered permanent dentition.

> In deep impinging overbite, the lower incisors must be destroying the soft tissue of the palate. Contact only does not constitute deep impinging overbite under the Orthodontic Services for Handicapping Malocclusion Program.

> For crossbite of individual anterior teeth to qualify as a condition of handicapping malocclusion, there must be evidence of soft tissue destruction (e.g., stripping of the labial gingival tissue on the lower incisors).

> Bi-lateral crossbite is not a benefit of the Orthodontics for Handicapping Malocclusion Program.

> Replacement retainers are a onetime only benefit unless documentation identifies an unusual situation requiring an additional replacement.

> Extraction of asymptomatic teeth is not a benefit. However, extractions that are required to complete medically necessary orthodontic dental services may be considered symptomatic when documented.

(Denti-Cal Provider Manual 5-77)

531-11F
Under a special program available to patients from birth to age 21, California Children Services (CCS) authorizes orthodontic and dental services to correct birth defects or other serious physical conditions resulting from disease, accident or other causes. Patients must apply to CCS to be eligible for services under this program.

Orthodontic Services

Orthodontic treatment is a benefit of the CCS program and payable under the Denti-Cal program for cleft lip, cleft palate or craniofacial anomaly cases only. Denti-Cal will deny a claim for the treatment of malocclusion for a CCS patient.

Treatment Authorization Requests (TARs) for CCS orthodontic patients should be submitted to the CCS regional or county offices. Denti-Cal cannot process TARs for orthodontic treatment of CCS patients. Denti-Cal only processes claims if they are stamped "CCS Approved" and signed and dated by a CCS representative.

When submitting a claim for orthodontic services, providers must include documentation diagnosing the patient's condition, for example "cleft palate" or "craniofacial anomaly." When submitting a claim for cleft lip/palate cases, providers must include documentation describing the dentition phase, for example "primary," "mixed" or "permanent."

Procedures 551, 557 and 558 are not benefits authorized by the CCS program for Medi-Cal beneficiaries. When a patient has been treated with the maximum monthly adjustments, no additional adjustments can be allowed unless CCS has authorized the additional treatment.

Retainers are a benefit following the completion of all monthly adjustments for facial growth management cases. For cleft palate cases, retainers are a benefit at the completion of each phase of treatment.

Under the CCS program, procedure 592 is a "pre-treatment" quarterly observation for facial growth management cases prior to starting orthodontic treatment. Documentation

of the craniofacial anomaly must be indicated in the Comments area of the claim form or the authorization form attached to the claim.

(Denti-Cal Provider Manual 5-82, revised January 2002, and renumbered effective May 2002; these sections were removed from the Denti-Cal Provider Manual effective August 2002)

531-11G
The California Department of Health Services established regulations implementing the EPSDT program within Medi-Cal. The applicable are §§51184, 51242, 51304, 51340, 51340.1, and 51532.

Whenever a Medi-Cal dental provider completes an oral examination on a beneficiary under the age of 21, an EPSDT screening service (and diagnostic service) has occurred. Any further treatment resulting from that examination is considered to be an EPSDT dental service - provided that the dental procedure is contained within the Medi-Cal dental program's scope of benefits.

EPSDT beneficiaries may require dental services that are not part of the current Medi-Cal dental scope of benefits. Conversely, the dental service may be part of the Medi-Cal dental scope of benefits for adults but not for children; or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by the Medi-Cal dental program. In these cases, such dental services are called EPSDT Supplemental Services (EPSDT-SS).

Prior Authorization Required

All EPSDT Supplemental Services must be prior authorized.

The EPSDT-SS TAR must be accompanied by the following patient case information:

1) Principal diagnosis and any significant associated diagnoses.

2) Prognosis of the patient's case, both with and without the requested treatment.

3) Etiology of the patient's dental disease(s) or condition(s), with date of onset (if known).

4) Clinical significance of the patient's dental disease(s) or condition(s) or the functional impairment caused by the patient's dental disease(s) or condition(s).

5) If the services of other dental providers (including dental specialists) will be required, then a complete case management plan (including coordination of care) must be presented - this plan must explain the therapeutic goals to be achieved by each dental provider, and the anticipated time for achievement of goals.

6) If the requested dental services are necessary in order to correct or ameliorate a non-dental disease or condition, then supporting documentation from the appropriate health care provider is required.

7) The extent to which dental services have been previously provided to address the dental disease(s) or condition(s) and the past clinical outcomes.

The dental provider should attach any additional documentation (e.g., narrative, radiographic, photographic) that is needed to fully justify the medical necessity and appropriateness of the requested services to the EPSDT-SS TAR. Medi-Cal dental program consultants will use the following guidelines:

1) The requested dental services must be necessary to correct or ameliorate diseases, defects and conditions.

2) The services shall not be requested solely for the convenience of the beneficiary, family, dental provider or another provider of services.

3) The services must not be unsafe for the individual patient and are not experimental.

4) The services must not be primarily cosmetic in nature nor primarily for the purpose of improving the patient's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the patient's appearance.

5) Where alternative dental treatment is available and such alternative treatment lies within the professional standard of care, the requested services must be the most cost-effective.

6) The requested services must be generally accepted by the professional dental community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence. The evidence shall demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.

7) The requested services must be within the authorized scope of practice of the dental provider and are an appropriate mode of treatment for the dental condition of the beneficiary.

8) The predicted beneficial outcome of the services must outweigh potential harmful effects.

All EPSDT-SS requests for orthodontic services must include a completed Handicapping LabioLingual Deviation (HLD) Index Scoresheet. The review of active orthodontic services also requires the submission of study models.

(Denti-Cal Procedures Manual 5-83 through 5-85, revised January 2002, and as renumbered effective May 2002; these sections were removed from the Denti-Cal Provider Manual effective August 2002)

531-11H
The Denti-Cal Provider Manual contains the complete Manual of Criteria for Medi-Cal authorization (Dental Services). Orthodontic services for Handicapping Malocclusion are

covered as follows:

1. Maxillofacial dental services are covered, subject to prior authorization, when necessity is justified and documented by a dentist qualified under §51223 of Title 22, California Code of Regulations (CCR).

2. For the purpose of this section, maxillofacial dental services means anatomic and functional reconstruction of those regions of the mandible and maxilla and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congential malformations, and the diagnosis and treatment of temporomandibular joint dysfunction. These procedures may be subject to review by the Department.

3. Orthodontic services are covered in the treatment of cleft palate deformities when under the case management and authorization of California Children Services (CCS) program or when documented and medically necessary under the orthodontic dental services program.

4. Maxillofacial surgical and prosthetic services and temporomandibular joint (TMJ) dysfunction services requests shall be audited individually to determine necessity and reasonableness relative to the intent of the regulations. No requested service will be automatically denied because it does not specifically appear on the list of program benefits and services.

5. All maxillofacial surgical and prosthetic services, TMJ dysfunction services, and orthodontic services require prior authorization except for diagnostic services and those services rendered on an emergency basis. Authorizations by CCS and GHPP (Genetically Handicapped Persons Program) are valid but must meet eligibility, program, and billing requirements.

6. The requirement for prior authorization may be waived where existing medical conditions or a time factor relating to treatment of the patient makes it inappropriate or impossible to obtain adequate preoperative diagnostic information or to delay treatment (i.e., surgical obturator). Approval for payment of services provided in such circumstances rests with the Department, based on submitted documentation justifying failure to obtain prior authorization. Final authority for establishment of the scope and level of benefits and allowable fee to such benefits resides with the Department.

7. Providers should be aware of the separate, specific procedure numbers identifying the maxillofacial and orthodontic services. Frequently, out-of-date or inappropriate procedure numbers or codes have been used by providers in an effort to describe services which are not specifically listed under the schedule of benefits of the maxillofacial/orthodontic dental program. Inappropriate procedure numbers must be modified to reflect maxillofacial dental services when possible. Some procedure numbers (i.e., Nos. 112, 125, 200 etc.) resist modification, however, and must stand as listed.

(Denti-Cal Provider Manual 4-37, 38, as revised December 1999)